TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Spine Joint

Respondent Name
Pacific Indemnity Co

MFDR Tracking Number
M4-16-3448-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Additionally, the Hospital's position is that the bill has been properly coded and all modifiers are included. Therefore, the Hospital is entitled to payment for the services rendered, in accordance with the fee guidelines."

Amount in Dispute: $49,072.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our supplemental response for the above referenced medical fee dispute resolution is as follows: the bills in question were escalated and the review has been finalized. Our bill audit company has determined no further payment is due."

Response Submitted by: Gallagher Bassett, 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2015	Outpatient Hospital Services	$49,072.31	$7,034.94

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

- 160 – This charge denied because an invalid code was submitted on the bill or the bill has missing or invalid required information
- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
- W3
- 193

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services which are:

1. **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
   To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.
2. **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.
3. **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
4. **Composite** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable fee pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute were denied with adjustment/reason code(s) 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication" and X160 – "This charge denied because an invalid code was submitted on the bill or the bill has missing or invalid required information." Review of the submitted medical claim finds charges related to surgery performed in an outpatient setting and physical therapy services. 28 Texas Administrative Code §134.403 (d) states in pertinent part,

> For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…

Review of the submitted codes related to the outpatient surgery finds the following:

- Procedure code J0690 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J1170 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2175 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J7120 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code C1713 has status indicator N denoting packaged items and services with no separate APC payment.
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- Procedure code 81025 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 36415 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85027 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 80048 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 73700, date of service July 10, 2015, has status indicator Q3 denoting conditionally packaged codes that may be paid through a composite APC.
- Procedure code 73590 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.
- Procedure code 76376 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 27535 has status indicator C denoting inpatient procedures not paid under OPPS. Per the Medicare Claims Processing Manual 100-04, Chapter 4 - Part B Hospital, Section 180.7 which states in pertinent part,

"inpatient-only" service furnished to a person who is registered in the hospital as an outpatient and reports the service on the outpatient hospital bill type (TOB 13X). CMS also does not pay for all other services on the same day as the "inpatient only" procedure.

There are two exceptions to the policy of not paying for outpatient services furnished on the same day with an "inpatient-only" service that would be paid under the OPPS if the inpatient service had not been furnished:

Exception 1: If the "inpatient-only" service is defined in CPT to be a "separate procedure" and the other services billed with the "inpatient-only" service contain a procedure that can be paid under the OPPS and that has an OPPS SI=T on the same date as the "inpatient-only" procedure, then the "inpatient-only" service is denied but CMS makes payment for the separate procedure and any remaining payable OPPS services.

Review of the medical bill finds an exception was allowed as a separate procedure with status indicator of "T" than can be paid.

- Procedure code 27405 has status indicator T denoting a significant procedure subject to multiple-procedure discounting.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code A9270, date of service July 15, 2015, has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code 93005 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.
- Procedure code G0378 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

Review of the applicable Medicare payment policy finds the services represented by the above codes were valid and required no modifier. The carrier's denial is not supported. These services will be reviewed per applicable rules and fee guidelines.

The carrier denied the services related to physical therapy with denial code 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing."

- Procedure code 97110 has status indicator A, denoting services paid under a fee schedule or payment system other than OPPS.
- Procedure code 97535 has status indicator A, denoting services paid under a fee schedule or payment system other than OPPS.
- Procedure code 97535 has status indicator A, denoting services paid under a fee schedule or payment system other than OPPS.
- Procedure code 97116 has status indicator A, denoting services paid under a fee schedule or payment system other than OPPS.
- Procedure code 97001 has status indicator A, denoting services paid under a fee schedule or payment system other than OPPS.
- Procedure code 97535, date of service July 15, 2015, has status indicator A, denoting services paid under a fee schedule or payment system other than OPPS.
- Procedure code 97116, date of service July 15, 2015, has status indicator A, denoting services paid under a fee schedule or payment system other than OPPS.

Review of the Medicare Claims Processing Manual 100-04, Chapter 5 states in pertinent part,

G. Required Reporting of Functional G-codes and Severity Modifiers

The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims at certain specified points during therapy episodes of care. Claims containing these functional G-codes must also contain another billable and separately payable (non-bundled) service. Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC).

Functional reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims:

• At the outset of a therapy episode of care (i.e., on the claim for the date of service (DOS) of the initial therapy service);

• At least once every 10 treatment days, which corresponds with the progress reporting period;

• When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004) is furnished and billed;

• At the time of discharge from the therapy episode of care–(i.e., on the date services related to the discharge [progress] report are furnished);

Based on above, the carrier's denial is supported. No additional payment can be recommended.

2. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent;

The remaining services in dispute are reimbursed based on the following:

Submitted code	Status Indicator	Composite criteria met	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index/0.8431	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
73700	Q3	no	332	$120.02	$120.02 x 60% = $72.01	$72.01 x 0.8431 = $60.71	$120.02 x 40% = $48.01	$60.71 + $48.01 = $108.72	$108.72 x 200% = $217.44
27405	T	n/a	0051	$3,763.00	$3,763.00 x 60% = $2,257.80	$2,257.80 x 0.8431 = $1,903.55	$3,763.00 x 40% = $1,505.20	$1,903.55 + $1,505.20 = $3,408.75	$3,408.75 x 200% = $6,817.50
								Total	$7,034.94

3. The maximum allowable reimbursement for the eligible service is $7,034.94. The carrier paid $0.00. The remaining balance of $7,034.94 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $7,034.94.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $7,034.94 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.